(3) Travel costs.
(4) The costs of feasibility studies.

**405 IAC 1-14.5-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 16. (a) The basis used in computing the capital return factor shall be the historical cost of all assets used to deliver patient related services, provided the following:
(1) They are in use.
(2) They are identifiable to patient care.
(3) They are available for physical inspection.
(4) They are recorded in provider records.
If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the capital return factor.
(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual or historical financial report, and the complete schedule shall be submitted to the office upon request.
(c) Assets used in computing the capital return factor shall include only items currently used in providing services customarily provided to patients.
(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.
(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and an historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.
(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arm's-length sale, or, if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. If the provider and the donor are related parties, the net book value of the asset to the donor shall be the basis, not to exceed fair market value. Cash donations shall be treated as revenue items and not as offsets to expense accounts.

**405 IAC 1-14.5-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 17. (a) If a facility is sold or leased within eight (8) years of the seller's/lessor's acquisition date, and this transaction is recognized as a change of provider status, the buyer's/lessee's property basis in facilities and equipment shall be the seller's/lessor's historical cost basis plus one percent (1%) of the difference between the purchase price, or appraised value if lower, and the seller's/lessor's historical cost basis for each month the seller/lessor has owned/leased the property.
(b) Leases shall be subject to the following purchase equivalency test based on the maximum capital return factor. The provider shall supply sufficient information to the office so as to determine the terms and conditions of a purchase that would be equivalent to the lease agreement. Such information shall include the following:
(1) Property basis and fair market value on the initial lease effective date.
(2) Inception date of the initial agreement between lessee and lessor.
(3) Imputed or stated interest rate.
(4) Duration of payments.
(5) Renewal options.

Such purchase equivalency terms and conditions shall be utilized to calculate the capital return factor as if it were a purchase. The provisions of section 15(c) through 15(d) of this rule shall apply. The lease payments determined under this section shall be subject to the limitations under section 15(b) of this rule.
(c) Where the imputed or stated interest rate is a variable rate, it shall be recognized provided the rate is reasonable and only if such arrangement was incorporated into the lease agreement at the time of acquisition.
(d) All leases, rental agreements, and contracts involving the use of property shall be subject to the same limitations as owners of property. The use fee calculation for variable rate leases will be calculated in the same manner as that set forth in section 13(k) of this rule. In no event shall the capital return factor be greater than the actual lease payment.
(e) If a provider rents, leases, or purchases facilities or equipment from a related party, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the capital return factor except as described in this section for the sale of facilities between family members.
(f) The sale of facilities between family members shall be eligible for consideration as a change of provider status transaction if all of the following requirements are met:
(1) There is no spousal relationship between parties.
(2) The following persons are considered family members:
(A) Natural parent, child, and sibling.
(B) Adopted child and adoptive parent.
(C) Stepparent, stepchild, stepsister, and stepbrother.
(D) Father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law.
(E) Grandparent and grandchild.
(3) The provider can demonstrate to the satisfaction of the office that the primary business purpose for the sale is other than increasing the established rate.
(4) The transfer is recognized and reported by all parties as a sale for federal income tax purposes.
(5) The seller is not associated with the facility in any way after the sale other than as a passive creditor.
(6) The buyer is actively engaged in the operation of the facility after the sale with earnings from the facility accruing to at least one (1) principal buyer primarily as salaries or self-employment income and not as leases, rents, or other passive income.
(7) This family sale exception has not been utilized during the previous eight (8) years on this facility.
(8) None of the entities involved is a publicly held corporation as defined by the Securities and Exchange Commission.
(9) If any of the entities involved are corporations, they must be family owned corporations, where members of the same family control the corporations through ownership of fifty percent (50%) or more of the voting stock.
(g) In order to establish an historical cost basis in the sale of facilities between family members, the buyer shall obtain a Member Appraiser Institute (MAI) appraisal, which appraisal is subject to the approval of the office. The appraisal shall be done within ninety (90) days of the date of the sale. The historical cost basis shall be the lower of the historical cost basis of the buyer or ninety percent (90%) of the MAI appraisal of facilities and equipment.
(h) If the conditions of this section are met, the cost basis and financing arrangements of the facility shall be recognized for the purpose of computing the capital return factor in accordance with this rule for a bona fide sale arising from an arm's-length transaction.
(i) If a lease of facilities between family members under subsection (f)(2) qualifies as a capitalized lease under guidelines established by the American Institute of Certified Public Accountants, the transaction shall be treated as a sale of facilities between family members for purposes of determining the basis, cost, and valuation of the buyer's capital return factor component of the Medicaid rate.

**405 IAC 1-14.5-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 18. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.
(b) Payments that must be reported on the annual or historical financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.
(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

**405 IAC 1-14.5-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation**

**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 19. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided such employees are engaged in patient care-related functions and that compensation amounts are reasonable and allowable under this section and sections 20 through 26 of this rule.
(b) The provider shall report on the financial report form in the manner prescribed using the forms prescribed by the office, all patient related staff costs and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported. Staffing limitations to determine Medicaid allowable cost shall be based on hours worked by personnel. If a service is performed through a contractual agreement, imputed hours for contracted services shall be reported. Hours for laundry and therapy services in nursing facilities, whether paid in-house or contracted, shall not be included in calculating the staffing limitation, but shall be reported on the financial report form using the forms or in the format prescribed by the office.
(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.
(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be subject to the total staffing limitations and allowed if the compensation paid to owner/related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owner/related parties is not subject to the limitation found in section 20 of this rule.

**405 IAC 1-14.5-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 20. (a) Compensation for owner, related party, management, consultants who perform management functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policy making, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks.
(b) The maximum amount of owner, related party, management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (d), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient related wages, salaries, or fees actually paid or withdrawn which were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.
(c) In addition to wages, salaries, and fees paid to owners under subsection (b), the office will allow up to twelve percent (12%) of the appropriate schedule for fringe benefits, business expenses charged to an operation, and other assets actually withdrawn that are patient related. These expenses include fringe benefits that do not meet nondiscriminatory requirements of the Internal Revenue Code, entertainment, travel, or continuing education. Other assets actually withdrawn include only those items that were actually accrued and subsequently paid during the cost reporting period in which personal services were rendered and reported to the federal Internal Revenue Service as fringe benefits, expenses, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.
(d) The owner, related party, and management compensation and expense limitation per operation effective July 1, 1997, shall be as follows:

| | OWNER AND MANAGEMENT COMPENSATION | OWNER'S EXPENSE |
|---|---|---|
| BEDS | ALLOWANCE | (12% X Bed Allowance) |
| 10 | $22,500 | $2,700 |
| 20 | $30,019 | $3,602 |
| 30 | $37,513 | $4,502 |
| 40 | $44,998 | $5,400 |

| | | |
|---|---|---|
| 50 | $52,517 | $6,302 |
| 60 | $57,019 | $6,842 |
| 70 | $61,524 | $7,383 |
| 80 | $66,023 | $7,923 |
| 90 | $70,510 | $8,461 |
| 100 | $75,013 | $9,002 |
| 110 | $81,046 | $9,726 |
| 120 | $87,037 | $10,444 |
| 130 | $93,066 | $11,168 |
| 140 | $99,040 | $11,885 |
| 150 | $105,052 | $12,606 |
| 160 | $111,040 | $13,325 |
| 170 | $117,054 | $14,046 |
| 180 | $123,048 | $14,766 |
| 190 | $129,058 | $15,487 |
| 200 | $135,050 | $16,206 |
| 200 and over | $135,050+ | $16,206+ |
| $250/bed over 200 | $30/bed over 200 | |

This subsection applies to each provider of a certified Medicaid operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

**405 IAC 1-14.5-21 Staffing costs in nursing facilities**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 21. Subject to the exclusions specified in section 19(b) of this rule, recognition of the costs related to total staffing requirements will be limited to five and one-half (5 1/2) hours worked per patient day in nursing facilities providing skilled care and four and one-fourth (4 1/4) hours worked per patient day in nursing facilities providing intermediate care. Hours worked exclude vacation, sick, and holiday pay.

**405 IAC 1-14.5-22 Medical or nonmedical supplies and equipment**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 22. (a) The approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supply items, and the provider shall not bill the Medicaid program for such items in addition to the established rate. under no circumstances shall medical or nonmedical supplies and equipment be billed through a pharmacy or other provider.

**405 IAC 1-14.5-23 Nursing facilities providing intermediate and skilled care; reimbursement for therapy services**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 23. (a) Therapy services provided to Medicaid recipients by nursing facilities providing intermediate care or skilled care are to be included in the established rate. Under no circumstances shall therapies be billed to Medicaid through any provider. Services which may be reported in the cost report used to determine the established rate include the following:
(1) Audiology.
(2) Physical therapy.
(3) Speech therapy.
(4) Occupational therapy.
(5) Respiratory therapy.
All such services shall be provided and reimbursed only if they meet the conditions as prescribed in the Indiana Medicaid provider manual for nursing facilities providing intermediate care or skilled care.
(b) A nursing facility providing intermediate care or skilled care may elect to provide therapy services if either of the following conditions are met:
(1) The facility employs licensed/certified therapists as members of its staff.
(2) The facility has a contract with a licensed/certified therapist or therapy agency to provide services to residents of the facility.

**405 IAC 1-14.5-24 Nursing facilities providing intermediate care and skilled care; allocation of intermediate and skilled care costs**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 12-13-7-3; IC 12-15**

Sec. 24. (a) The detailed basis for allocation of expenses between different levels of care and special services (HIV) in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.
(b) However, the following relationships shall be followed:
(1) Reported expenses and patient census information must be for the same reporting period.
(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.
(3) Any change in the allocations must be approved by the department prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the department for approval at least ninety (90) days prior to the provider's reporting year end. If a change in allocation basis has not been approved by the department, the provider shall not submit cost reports using a new allocation basis.
(4) The allocation basis for the capital return factor calculated under sections 12 through 17 of this rule shall be patient days, unless a different allocation methodology was approved prior to October 1, 1990, and the provider has not changed the number of beds in either level of care since October 1, 1990. In those instances, the previously approved allocation methodology may be continued.

**405 IAC 1-14.5-25 Administrative reconsideration; appeal**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**
**Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15**

Sec. 25. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).
(b) If the provider disagrees with a rate redetermination resulting from an audit adjustment or reportable condition affecting a rate, the provider must request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).
(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5-3.
(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process in accordance with section 1(d) of this rule.

**405 IAC 1-14.5-26 Nursing facilities; separate add-on reimbursement for chronically medically dependent people infected by the human immunodeficiency virus (HIV)**
**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; P.L. 96-1990, SECTION 27**
**Affected: IC 12-13-7-3; IC 12-15; IC 16-10-1; IC 16-10-4**

Sec. 26. (a) Care for a chronically medically dependent person may be reimbursed under this section to those providers of skilled or intermediate nursing services who provide the required level of care.
(b) Costs that are reimbursed under this rate must meet the following conditions:
(1) Be determined in accordance with a prospective payment rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care and services in conformity with applicable state and federal laws, rules, regulations, and quality and safety standards.
(2) Include, to the extent permitted by federal laws and regulations, increased costs for:
(A) respiratory therapy;
(B) intensive case management;
(C) medically-related social services;
(D) physician and nursing care;
(E) linens; and
(F) dietary supplements.
(c) Recognition of the costs related to total staffing will be limited to an overall staffing limit for all personnel of not more than eight (8) hours per patient day for skilled level of care, and not more than six (6) hours per patient day for intermediate level of care.
(d) No cost recognition will be included in the per diem for those services provided by a health care provider which are being separately reimbursed by the Medicaid program.
(e) Rate requests to establish initial interim rates for a new operation or a new type of certified service, or for a change of provider status, shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date or establishment of a new service. Initial interim rates will be set at the greater of the prior provider's then current rate, if applicable, or the fiftieth percentile rate. Initial interim rates shall be effective upon certification or the date a service is established, whichever is later. The fiftieth percentile shall be computed on a statewide basis for like levels of care using current rates of all nursing facility providers. The fiftieth percentile rate shall be maintained by the office, and a revision shall be made to this rate four (4) times per year effective on March 1, June 1, September 1, and December 1.
(f) The provider shall file a nine (9) month historical financial report within sixty (60) days following the end of the first nine (9) months of operation. The nine (9) months of historical financial data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of the calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of operation.
(g) If the provider fails to submit the nine (9) months of historical financial data within ninety (90) days following the end of the first nine (9) months of operation, and an extension had not been granted, the initial rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after receipt of the report by the office.
(h) Providers of special skilled and intermediate services licensed under IC 16-10-4 that have been approved by the office must have more than eight (8) beds but less than forty (40) beds approved for this type of service. Bed allocation will be based upon locality and reasonableness on a first come first served basis.
(i) The office may not approve more than one hundred (100) beds for special skilled or intermediate services without the agreement of the secretary of Indiana family and social services administration, the commissioner of the Indiana state department of health, and the assistant secretary of the office.
(j) Allowable costs per patient day for certain fixed costs shall be determined based on an occupancy level equal to the greater of ninety percent (90%) effective with the effective date of this rule or actual occupancy based on beds available to the program. The fixed costs subject to this minimum occupancy level standard include the capital return factor determined in accordance with sections 12 through 17 of this rule.

(b) The amortization period to be used in computing the use fee shall be the greater of twenty (20) years or the actual amortization period for the facility and for facilities and equipment where a single lending arrangement covers both. Where equipment is specifically financed by means of a separate lending arrangement, a minimum of seven (7) years shall be the amortization period. Provided, however, that a mortgage existing on April 1, 1983, has a fully amortizing life of less than twenty (20) years, the use fee will be calculated using the actual life of the lending arrangement, but not less than twelve (12) years.

(c) The use fee component of the capital return factor shall be limited by the lessor of:

(1) the original loan balance at the time of acquisition;

(2) eighty percent (80%) of historical cost of the facilities and equipment; or

(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (1/2) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) or the actual interest rate, whichever is lower. For property financing with a fixed interest rate, the date that the financing commitment was signed by the lender and borrower shall be the date upon which the allowable rate shall be determined. For property financing with a variable interest rate, the allowable interest rate shall be determined each year at the provider's report year end.

(e) The use fee determined under this section shall be subject to the limitations under section 15(b) of this rule.

(f) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing arrangements shall be recognized only when the interest rate is less than the original financing,

on or after the effective date of this rule, the return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(c) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the United States Treasury bond, thirty (30) year amortization, constant maturity rate on the last day of the reporting period, plus three percent (3%), whichever is higher.

**405 IAC 1-12-15 Allowable costs; capital return factor; use fee; depreciable life; property basis**

**Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2**

**Affected: IC 12-13-7-3; IC 12-15**

Sec. 15. (a) The following is a schedule of allowable use fee lives by property category:

| Property Basis | Use Fee Life |
|---|---|
| Land | 20 years |
| Land improvements | 20 years |
| Buildings and building components | 20 years |
| Building improvements | 20 years |
| Movable equipment | 7 years |
| Vehicles | 7 years |

The maximum property basis per bed at the time of acquisition shall be in accordance with the following schedule:

years for beds acquired on or after April 1, 1983, and twelve (12) years for beds acquired before April 1, 1983; and

(C) the allowable interest rate is the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(2) The equity portion of the maximum capital return factor is calculated based on:

(A) the allowable equity as established under section 14 of this rule; and

(B) the rate of return on equity is the greater of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) on the last day of the reporting period minus one percent (1%), or the weighted average of the United States Treasury bond, thirty (30) year amortization, constant maturity rate plus three percent (3%), rounded to the nearest one-half percent (0.5%) plus one percent (1%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

(c) For facilities with a change of provider status, the allowable capital return factor of the buyer/lessee shall be no greater than the capital return factor that the seller/lessor would have received on the date of the transaction, increased by one-half (1/2) of the percentage increase (as measured from the date of acquisition/lease commitment date by the seller/lessor to the date of the change in provider status) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average). Any additional allowed capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had incurred the additional capital expenditures.

(d) The following costs which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Indiana Medicaid program shall not be recognized as an allowable cost: